SPECIAL CONSENT TO
PERFORMANCE OF
ORTHODONTIC TREATMENT
NAVMED 6630/7 (1-81)

A. IDENTIFICATION

1. OPERATION OR PROCEDURE: _____

_____

B. STATEMENT OF REQUEST

1. The nature and purpose of the above-named procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the procedure. I understand the nature of the procedure to be _____
(description of procedure in layman's language)

_____

_____

_____

_____

which is to be performed by or under the direction of Dr. _____

or other orthodontic staff members of _____

_____

2. I request the performance of the above-named orthodontic procedure and of such additional operations or procedures (specifically including the extraction of permanent teeth) as are found to be necessary or desirable, in the judgment of the professional orthodontic staff of the below-named dental facility, during the course of the above-named procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named dental facility.

4. I understand that, because of the limited number of orthodontists and facilities, such treatment may not be available to me upon my transfer from this facility or that of my sponsor, or the transfer of the orthodontist from this facility, or upon the cessation of my eligibility under applicable law.

5. If my orthodontic treatment is discontinued for any of the reasons indicated in paragraph 4 above, I understand it will be my responsibility to obtain further treatment, if I so desire, from a civilian orthodontist. For this civilian service, my new orthodontist will charge his customary fee, the payment for which the U.S. Navy will in no way be responsible. If I desire not to continue treatment with a civilian orthodontist upon discontinuance of my military treatment, I may elect to have my orthodontic appliances removed. I understand that, after such removal, relapse will occur. It has further been explained to me that after initiation, orthodontic treatment should be continued to completion, especially in situations involving extraction of permanent teeth.

6. I request the disposal by authorities of the below-named dental facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this orthodontic procedure, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the procedure by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not to be used to identify said pictures.

b. Said pictures will be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in parts A and B must be completed before signing)*

1. Counseling Dentist: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

_____
(Signature of Counseling Dentist)

2. Patient: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date/Time)*

3. Sponsor or Guardian: *(When patient is a minor or unable to give consent)*

I, _____

sponsor/guardian of _____

understand the nature of the proposed procedure(s), attendant risks involved, and expected results, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor/Legal Guardian)*	*(Date/Time)*

PATIENT'S IDENTIFICATION *(Name–Last, First, Middle; Grade; Date)*	DENTAL FACILITY